STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295044	A. BUILDING _____ B. WING _____	C 04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE OF NORTHERN NEVADA	1950 BARING BLVD SPARKS, NV 89434

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 4/23/08-4/24/08. Complaint #NV00017963 alleged that a resident received poor quality of care and that the family was not notified of a significant change of condition. This complaint was partially substantiated with deficiency cited. See F157. Complaint #NV00017982 was a facility reported incident that alleged a certified nursing assistant was inappropriate with a resident. This complaint was substantiated with deficiency cited. See F225. Complaint #NV00017417 alleged neglect of one resident. This complaint was substantiated with deficiency cited. See F281. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or	F 157	F157 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident #1 was discharged.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 5/16/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to notify the designated representative family member of significant change of condition for 1 of 3 residents. (#1) Findings include: Resident #1: The resident was most recently admitted to the facility on 2/12/08, although she had been a resident of the facility off and on since 1999. Her admitting diagnoses included cellulitis of the leg, decubitus ulcer, chronic obstructive airway disease, peripheral vascular disease and congestive heart failure. Review of the resident's	F 157	2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; • Re-education of the policy and procedure in notification of change on 5/14/08. • The charge nurses will complete the Change in Condition form on every change observed. • DON/designee will complete a round sheet in A.M. and P.M. to verify Change in Condition form completed by the charge nurses reflected on 24-hour report supported with nurse's notes stating the notification of responsible party and MD and care plan addressing the change. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. • Monthly review at QOC meeting. • Track and trend results at monthly PI meeting.	

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F 157	Continued From page 2 face sheet in the record revealed that her granddaughter was the designated emergency family contact. On 4/23/08, Resident #1's medical record was reviewed. Her physician orders included oxygen continuously at 2-4 liters per minute via nasal cannula, nebulizer treatments with Albuterol and Atrovent four times a day, Percocet 5/325 milligrams (mg) every four hours as needed (prn) for pain, Morphine Sulfate (MS) 20 mg/ml sublingual (SL) for pain, and an order obtained on 4/11/08 for Lorazepam 0.5 mg for anxiety. The nurse's notes, dated 4/11/08 documented the following: 4:30 AM, "Up in chair, to bed x 1 for 15 minutes for pericare then back up in chair. Incontinent of urine." 3:00 PM, "Resident c/o (complained) SOB (shortness of breath). Administered neb treatment stat-small amount of relief. c/o pain in lungs and low back. Administered Percocet 5/325. She requested another Percocet-denied." 3:30 PM, "Administered MS SL 0.25 cc- small amount of relief. Notified (physician assistant). She ordered Lorazepam 0.5 mg-administered @ 4:00 PM. Resident is still c/o SOB. Will continue to monitor. VS 96.7-93-20, 160/115. Daughter notified 5:30 PM. Resident transferred to acute hospital emergency room (ER) @4:37 PM." Review of the physician's progress note for the visit of 4/11/08 revealed the physician assistant (PA) saw the resident and documented the following in her notes, "Patient c/o SOB and inability to let the air in. She just had NPPB (nebulizer) done. SAO2 90% on O2 (oxygen saturation on oxygen). She has mild cough, no	F 157	5. Dates when corrective action(s) will be completed; • Completed on 5/30/08.	

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F 157	Continued From page 3 chills, no fever. She has no chest pain, but some mild lower back at the level of coccyx." The PA recommended that the resident be sent to the ER, and documented in the interventions, "Patient refuses to go to ER! Increase O2 to 5L." Review of the resident's medication records revealed that the resident received nebulizer treatments on 4/11/08 at 6:00 AM, 12:00 PM, and immediate treatments at 3:00 PM and 4:00 PM. On 4/23/08, at 11:35 AM, the licensed practical nurse (LPN) taking care of the resident on 4/11/08, was interviewed. She stated that she had not received a call from the granddaughter on 4/11/08, and was not informed by any other staff member that she had called. She stated that the resident wore her oxygen at all times, even when she was receiving a nebulizer treatment. She confirmed that the resident had been wearing oxygen the entire day of 4/11/08. She confirmed that the resident had refused to go to the ER that day. She stated that the resident had finally said, "I guess I better go (to the hospital)." The LPN stated that the resident's daughter had called the resident's room around 5:30 PM on 4/11/08. She informed the daughter of the resident's change of condition and transfer to the ER. The LPN stated that this was approximately 45 minutes after the resident was transferred. On 4/23/08, the Unit Manager was interviewed. She stated that the facility policy was to notify the guardian or family member of any change of conditions. She stated that this information was available on the face sheet of the resident's chart. If that person was unable to be notified, that should be documented, and another family	F 157		

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F 157	Continued From page 4 member would be notified. On 4/24/08, the resident's son was interviewed. He stated that he was financial power of attorney for Resident #1, and that the granddaughter was the power of attorney for health care. He stated that neither party was aware of the resident's transfer to the hospital until a physician from the hospital called them.	F 157		
F 281 SS=G	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to monitor a resident's condition and failed to follow interventions for a fever in accordance with the facility standards of practice for 1 of 3 sample residents (#3). Findings include: Resident #3: The resident was admitted multiple times, with the most recent admit date of 3/6/08, with diagnoses that included cellulitis, vascular dementia, convulsions, anemia, and aphasia. The annual minimum data set (MDS) completed 1/22/08, indicated Resident #3's cognitive ability as severely impaired. Review of Resident #3's facility record revealed that she was re-admitted from an acute care hospital at 3:30 PM on 3/6/08. Her initial nursing assessment was completed on 3/6/08 with the comment written under Neuro/Cognitive,	F 281	F281 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The resident #3 was discharged. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice.	

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F 281	Continued From page 5 "Requires total care. Unable to communicate needs." Resident #3's nursing notes dated 3/22/08-3/27/08 were reviewed. On 3/23/08 at 6:00 PM, the following entry was noted, "Tylenol 650 mg po (by mouth) for temperature 100.3 at 2:30 PM with good effect. Fed dinner. Fluids taken well." Further review of the record failed to reveal that Resident #3's temperature or vital signs were taken again or that she was monitored in any way until the entry on 3/27/08 at 9:40 AM, "Resident is not eating. Increased weakness noted. Difficulty swallowing also noticed. ST (speech therapy) notified for swallowing screen. MD (medical doctor) notified." The next entry was documented at 11:05 AM on 3/27/08, "Found resident non-responsive. Labored breathing noted. O2 (oxygen) saturation 60-65% RA (room air)." (Normal O2 saturation is greater than 90%.) The resident was transferred to an acute hospital on 3/27/08. Resident #3's acute hospital record was reviewed. She had a do not resuscitate, do not intubate order at the skilled nursing facility. The emergency medical technicians were unclear about her advanced directives and she was intubated en route to the hospital for increasing respiratory distress. The emergency room physician documented the resident was in critical condition with apnea, dehydration, hypotension, increased white blood count, and hypernatremia. The admitting physician documented Resident #3 had "significantly dry" mucous membranes. Resident #3's admitting primary diagnoses were ventilatory-dependent respiratory failure, dehydration, and hypernatremia. Review of her lab values indicated a sodium level of 163	F 281	3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; • Re-education of the policy and procedure in notification of change on 5/14/08. • The charge nurses will complete the Change in Condition form on every change observed. • DON/designee will complete a round sheet in A.M. and P.M. to verify Change in Condition form completed by the charge nurses reflected on 24-hour report supported with nurse's notes stating the notification of responsible party and MD and care plan addressing the change. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. • Monthly review at QOC meeting. • Track and trend results at monthly PI meeting. 5. Dates when corrective action(s) will be completed; • Completed on 5/30/08.	

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F 281	Continued From page 6	F 281		

(normal value 137-145), a blood urea nitrogen of 29 (normal value is 7-17), creatinine of 1.5 (normal value is 0.7-1.2), and a white blood cell count of 27.4 (normal value is 4.37-10.68). The pulmonary consultant assessed the Resident on 3/27/08. In the history of present illness he documented, "she has cellulitis, or her decubitus ulcers as source of shock." His impressions included:
"1. Vent dependent respiratory failure.
2. Stage 1 sacral decubitus ulcers.
4. Septic shock with likely a secondary cellulitis or sacral decub for possibly C. difficile colitis.
10. Leukocytosis with 4% bands.
11. Thrombocytosis.
12. Profound hypernatremia.
13. Acute renal failure, the results of both of the above from likely dehydration."

On 3/27/08 Resident #3's vital signs recorded by the facility were temperature 98.0, pulse 122, respirations 22, and blood pressure 97/54. According to the Lippincott Manual of Nursing Practice, Sixth Edition, signs of hypernatremia include, "tachycardia (fast heart rate), hypotension (low blood pressure), dry, sticky, mucous membranes, and fever."

Resident #3 died on 3/28/08 at the acute care hospital. The physician's death summary from the acute care hospital documented that the "patient was also significantly dry and also had significantly elevated white blood count." "This patient's overall prognosis at the time of admission was extremely poor given the patient's long-standing history of dementia, her severe dehydration, her severe sepsis, and her severe hypotension." The cause of death was listed as:
"1. Sepsis

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F 281	Continued From page 7 2. Pneumonia 3. Dehydration 4. Septic Shock 5. Alzheimer dementia" On 4/23/08, the DON was interviewed. She stated that when a resident had a fever, the facility practice was for the resident to go on alert charting. She explained that alert charting meant that the resident would be monitored and charted on every shift for three days. In summary, review of Resident #3's medical record revealed that the resident was noted to have a fever at 2:30 PM on 3/23/07. Review of the March 2008 medication record revealed that the Resident was given Tylenol on 3/18/08 and 3/23/08. Review of the Resident's nurses notes failed to reveal nursing charting from the entry dated 3/23/08 at 6:00 PM until 9:40 AM on 3/27/08. The vital sign flow sheet documented that vital signs were taken 3/7/08-3/20/08, 3/23/08, and 3/27/08. Further review of the medical record failed to reveal monitoring of the fever noted on 3/23/07 in accordance with the facility's standard of practice as stated by the DON on 4/23/08.	F 281		